UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE JACKSONVILLE
Office of Graduate Medical Education

POLICY: APER, SR, IR, PIWP Policy and Procedure	
Approved by: GMEC	Page(s): 1 of 6
Approval date: 11/7/2023	Reviewed date: 3/4/14; 4/18/17; 5/29/20; 3/6/25
Effective date: 8/6/2013	Revised date: 5/17/18; 5/29/20; 10/2/23; 3/6/25

POLICY RATIONALE

The Accreditation Council for Graduate Medical Education (ACGME) tasks Sponsoring Institutions with the responsibility and authority to monitor compliance with Institutional and Program Requirements. As the Sponsoring Institution, the UFCOM-Jacksonville (UFCOM-J) must therefore comply with these requirements.

The Designated Institutional Official (DIO), in collaboration with the Graduate Medical Education Committee (GMEC), has the authority and responsibility for the oversight and administration of the Sponsoring Institution's ACGME-accredited programs and is responsible for assuring compliance with ACGME Institutional Requirements. The UFCOM-J DIO must therefore ensure these requirements are fulfilled by all accredited programs at the institution.

This UFCOM-Jacksonville policy serves to compile various policies related to ACGME oversight and administration requirements, including the Annual Program Evaluation (APE), the Annual Program Evaluation Review (APER), Special Review, Internal Review, and Internal Warning and Probation.

Section I.B.4. in the ACGME Institutional Requirements state:

I.B.4. Responsibilities: Graduate Medical Education Committee (GMEC) responsibilities must include:

I.B.4.a) Oversight of:

- I.B.4.a).(1) ACGME accreditation and recognition statuses of the Sponsoring Institution and each of its ACGME accredited programs; (Outcome)
- I.B.4.a).(2) the quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME accredited programs, and its participating sites; (Outcome)
- I.B.4.a).(3) the quality of educational experiences in each ACGME accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty-/subspecialty-specific Program Requirements; (Outcome)
- I.B.4.a).(4) the ACGME-accredited program(s)' annual program evaluation(s) and Self-Study(ies);(Core)
- I.B.4.a).(5) ACGME-accredited programs' implementation of institutional policy(ies) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence, at least annually; (Core)
- I.B.4.a).(6) all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution; and, (Core)
- I.B.4.a).(7) the provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided. (Detail)

The GMEC provides the required oversight through the Annual Program Evaluation and Review (APER) process.

ANNUAL PROGRAM EVALUATION REVIEW POLICY

Consistent with ACGME and UFCOM-J GMEC requirements, each program must be evaluated annually to assess the quality of the educational experiences that lead to successful educational outcomes.

The purpose of the annual evaluation is to perform a critical programmatic assessment and implement changes that will provide continual improvement in the quality of teaching and learning. Emphasis is placed

on the identification of issues affecting the program's educational effectiveness, analysis of these findings and an action plan for improvement.

APER PROCEDURE

STEP 1: PEC formation and responsibilities

The program director (PD) must appoint a Program Evaluation Committee (PEC); which must conduct and document formal, systematic evaluation of the curriculum at least annually and is responsible for rendering a written Annual Program Evaluation and Review (APER) form. The PEC must include at least two program faculty members, one of which must be core faculty, and at least one resident. The PEC responsibilities must include:

- review of the program's self-determined goals and progress toward meeting them;
- guiding ongoing program improvement, including development of new goals, based upon outcomes; and,
- review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims

The PEC must review program goals and objectives and the effectiveness of the program in achieving them. If the program also utilizes another participating institution (e.g., Baptist, Mayo, UF/Gainesville, etc.), representative faculty from these sites should be included in the process. All participation/attendance must be documented in the APER minutes.

STEP 2: Annual Program Evaluation components

The PEC must review the following elements, at a minimum, in its Annual Program Evaluation:

- the program's curriculum;
- ACGME letters of notification, including citations, areas for improvement, and comments;
- quality and safety of patient care;
- aggregate resident and faculty:
    - well-being,
    - recruitment and retention,
    - workforce metrics, including graduate medical education staff and other relevant academic community members,
    - engagement in quality improvement and patient safety, and
    - scholarly activity;
- ACGME Resident and Faculty Survey results;
- aggregate resident milestones evaluations;
- achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance;
- aggregate faculty evaluation and professional development;
- program mission and aims, strengths, areas for improvement, and threats; and
- review outcomes from prior APER submissions, aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program

STEP 3: Annual Program Evaluation outcomes

The PEC must prepare a written Annual Program Evaluation and Review (APER) form which includes explicit action plans to address areas for improvement and threats and documents initiatives to improve performance in the areas listed, including how they will be measured and monitored. The APER, including the action plan,

must be distributed to and discussed with the residents and teaching faculty, and be submitted to the DIO. The action plan is to be approved by the faculty and documented in the APER minutes.

APER PROGRAM REPORTING REQUIREMENTS:
The Annual Program Evaluation Review will be submitted to the Office of Graduate Medical Education (OGME) on the *Annual Program Evaluation and Review (APER) Form* by the annual due date set by the OGME and saved in the program's CAPER folder.

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Program leadership will be expected to maintain all updated data in designated folders located in the program's CAPER folder on the GME server. The data reviewed will be from the *Annual Program Evaluation and Review (APER) form*. Components to be reviewed include, but are not limited to:

- Annual Program Evaluation
- Faculty Lists
- ACGME Survey reports (residents and faculty)
- Previous Citations
- Board Certification
- In-training Exam Scores
- Scholarly Activity (residents and faculty)
- Clinical Measures
- Patient Safety
- Quality Improvement
- Supervision
- Professionalism
- Faculty Development
- Didactic Curriculum
- Milestones
- Rotation Review
- Case Logs
- Goals and Objectives
- CCC Semi-annual Assessment
- Learning and Working Environment
- Well-Being
- Evaluation Tools
- Transitions of Care

Programs' annual submissions, using the standard template form, are reviewed by the Committee on Annual Program Evaluation Review (CAPER), a subcommittee of the GMEC. The subcommittee members are appointed by the DIO and consist of program directors (PD), associate/assistant (ASO/AST) PDs, resident representative(s) and representatives from the major participating sites, including nursing, patient safety and administration. Each program is assigned a primary and secondary reviewer. The reviewers prepare an executive summary of their review and recommendations for improvement, as well as appropriate monitoring, which are then reviewed by the CAPER and presented to the GMEC for final review and approval. The program director or designee is invited to the GMEC to answer any questions from the committee.

The GMEC review will result in one of three possible outcomes:

- Continued Annual Review: If a program is deemed to be in significant compliance with program requirements
- Three to six-month Progress Report: If a significant number of areas of concern are identified, the program will be scheduled for a follow-up review and progress report submission. The subcommittee will review areas identified as non-compliant and/or needs improvement after the program resubmits the additional data.
- Special Review: If issues of significant concern and areas of non-compliance with program requirements are identified; the CAPER will require a Special Review (see below).

SPECIAL REVIEW PROTOCOL

The ACGME requires the institution, through the GMEC, to effectively oversee underperforming program(s) through a Special Review process (Institutional Requirement I.B.6.). The Special Review process must include a protocol that:

- establishes a variety of criteria for identifying underperformance that includes, at a minimum, program accreditation statuses of Initial Accreditation with Warning, Continued Accreditation with Warning, and adverse accreditation statuses as described by ACGME policies; and, (IR I.B.6.a.1.)
- results in a timely report that describes the quality improvement (QI) goals, the corrective actions, and the process for GMEC monitoring of outcomes, including timelines. (IR I.B.6.a.2.)

This protocol defines the method that the UFCOM-Jacksonville will use for its Special Review process, including the identification of criteria designated as underperformance, the components that make up a Special Review, the report that will be generated, and expectations of programs undergoing Special Review. The DIO (IR PR I.A.5.a.) and the GMEC (IR PR I.B.6.) will oversee the Special Review process, including its implementation and follow up.

Criteria that will trigger a special review include:

1. Program Accreditation Status concerns:
    a. Initial Accreditation with Warning
    b. Continued Accreditation with Warning
    c. Adverse accreditation statuses (Probation, Withdrawal)
2. CAPER reporting concerns, including substantial incompletion of a CAPER form submission, no evidence of an APE, or other concerns identified and agreed upon by a majority of CAPER members.
3. ACGME, Institutional, or Programmatic Survey results, or substantial resident/fellow concerns voiced by either the Resident/Fellow GMEC or a majority of a program's trainees sent directly to the DIO, that identify a significant resident safety concern that is deemed substantial enough to require immediate intervention.

The Special Review will specifically identify and target areas that require focused attention, based off of CAPER reviewer grading or from special concerns sent to the DIO. The OGME will create a tracking form to document these areas, and will send this form to the PD and Program Coordinator (PC), along with the Special Review committee members, prior to the meeting. The Program Director will be responsible for completing the Special Review document two weeks prior to the agreed-upon meeting date, which will be the method of providing information for committee review.

The Special Review panel will consist of the program's CAPER reviewers, a Resident/Fellow GMEC member not affiliated with the program under review, the Associate Dean for Graduate Medical Education, the Associate DIO, and the DIO. The Associate DIO, or their designee, will chair the committee.

The Special Review should occur within 60 days once its deemed necessary. Once the review is complete, an Executive Summary will be completed by the program's CAPER Primary Reviewer, along with the Associate DIO, within 10 days of the meeting, and submitted to the DIO for review. The Executive Summary will include QI goals, corrective actions, the process for ongoing GMEC monitoring and timelines within which the QI goals will be completed. Once approved by the DIO, the summary will be shared with the PD and will be submitted to the GMEC at the next GMEC meeting for review and approval. The PD will be responsible for submitting timely, required updates to the OGME as required by the Special Review Executive Summary.

INTERNAL REVIEW PROTOCOL

Internal reviews are conducted for programs in initial accreditation status. The reviews occur at the approximate midpoint between initial accreditation and the program's first ACGME RC Site Visit. An internal review panel is appointed by the DIO or designee, led by the Associate DIO and/or Associate Dean for Graduate Medical Education, and consists of individuals external to the program being reviewed (selected faculty, a hospital administrator, and a resident/fellow representative).

The PD and PC complete the Internal Review Program Evaluation Form. The panel meets with residents/fellows, faculty, and the PD and PC to review the data submitted on the form. After the meeting, the internal review report draft is submitted to the panel for review. A final internal review report with recommendations is submitted to the GMEC, DIO, and the PD. The Chair receives an executive summary of the report.

Materials Used:
The program director completes a standardized Internal Review form. Upon completion, it is submitted to the internal review panel for pre-review:

Faculty interview: Key faculty are interviewed regarding educational and clinical learning environment components.

Resident/Fellow interview: Program trainees are interviewed regarding educational and clinical learning environment components.

Educational components (as available): faculty list, survey results, initial accreditation citation(s), in-training examination, scholarly activity and selected clinical measures.

Clinical Learning Environment Components and Program Requirements (as available): patient safety-error reporting, patient safety-work in inter-professional teams, quality improvement, supervision, professionalism, faculty development, didactic curriculum, milestones, rotation reviews, case logs, goals and objectives, clinical competency committee, learning and working environment (duty hours), well-being, evaluations, transitions in care and the annual program evaluation.

Process:
A panel consisting, as described above, meets with the PD, Associate or Assistant (ASO/AST) PD, and/or PC to review the completed Internal Review APER form, and attached documentation. The results of the resident

and faculty surveys are discussed to corroborate information. Separate interviews are conducted with representative residents/fellows from the program under review, as well as with representative faculty.

Report:
The internal review report is comprised of all sections that correspond to the components of the Internal Review APER form including identification of compliant, needs improvement, and non-compliant with recommendations and follow-up. The report incorporates the program director's written responses, the internal review panel meeting and interviews with faculty and residents.

The executive summary includes a summation of the areas noted to be compliant, needing improvement, and non-compliant.

Recommendations and Continuous Quality Improvement:
The areas of concern are identified in the report. The program director, with the Program Evaluation Committee, develops a timeline for follow-up.

The GMEC reviews the final report for action and monitors progress in addressing deficiencies.

PROGRAM INTERNAL WARNING AND PROBATION POLICY
A program that fails to address GMEC concerns may be placed on internal warning or probation after significant efforts have been made to address ACGME compliance issues.

Consideration of internal warning or probation include concerns such as**:**

1. ACGME adverse accreditation status (warning, proposed probation, etc)
2. Special Review concerns not resolved in the timeline requested by the GMEC
3. RC citations not resolved in the timeline requested by the GMEC
4. Failure to adhere to institutional policies, procedures, or standards
5. Program board pass rates that do not meet institutional and RC requirements
6. Failure to address consistent clinical learning and work environment (formerly duty hours) violations (not individual resident logging issues)
7. Program Director leadership issues and/or frequent leadership changes
8. At the request of the DIO or Dean, College of Medicine-Jacksonville

Procedure:
The GMEC may receive a recommendation from the CAPER to place a program on institutional warning or probation. Programs that continue to neglect GMEC concerns, may receive adverse institutional action, including a request to move the program to "Inactive Status" or submit a request for "Voluntary Withdrawal of Accreditation" to the ACGME.